

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 12  
17-39  
37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAY 19 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19819

State File No. \_\_\_\_\_

Registration District No. 373

Primary Registration District No. 4474

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Sweet Springs  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Parsons-Doyle Clinic  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hr  
(Specify whether years, months or days)

In this community Transient

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Champaign <sup>999</sup>

(c) City or town Champaign <sup>0</sup>  
(If outside city or town limits, write "RURAL") <sup>2</sup>

(d) Street No. 1006 West Columbia  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WALTER LEWIN DONLEY

3. (b) If veteran, name war World War 2

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Div.

6. (b) Name of husband or wife Barabellie Donley

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 1 1910  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>6</u>	<u>2</u>	hr. _____ min.

9. Birthplace Champaign Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Electrician

11. Industry or business \_\_\_\_\_

12. Name Walter James Donley

13. Birthplace Urbana Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Violet Maude Hale

15. Birthplace Kenia Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter J. Donley

(b) Address Champaign, Illinois

17. (a) Removal (b) Date thereof 5-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Champaign, Ill.

18. (a) Signature of funeral director L. F. Parker

(b) Address Sweet Springs, Mo.

19. (a) 5/3/47 (b) Dolly Andrew  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3  
year 1947 hour 4:00 minute 0 M.

21. I hereby certify that I attended the deceased from 3 May 1947 to 3 May 1947, 19\_\_\_\_;  
that I last saw him alive on 3 May 1947, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
less than 1 hour

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Includes pregnancy within 3 months of death)

Major findings: Of operations 94A

Of autopsy \_\_\_\_\_

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Joseph J. Doyle M.D.

Address Sweet Springs Date signed 3 May 1947

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5-16-47

MAR 2 - 1948

MAR 22 1948

50  
43  
76

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed L. T. Parker

Licensed Embalmer No. 3840

P. O. Address Sweet Spring, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 343

Primary Registration District No. 477A

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Sweet Springs  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Water L. Donley

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced, divorced

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 1  
(Month) (Day) (Year)

8. AGE: Years 36 Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day)  
hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

{ 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

{ 14. Maiden name \_\_\_\_\_

{ 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Dolley Andrew  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
\_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-19819